THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF FRANCES BAYER

I, Frances Lucy Bayer, will say as follows: -

INTRODUCTION

1. I am a band 6 Care Co-ordinator ("**CCO**") working in NHFT's Early Intervention in Psychosis ("**EIP**") Service, City South. At work I use my maiden name, Frances Doughty.

2. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 27 October 2025 (the "**Request**").

3. I have been asked to provide a witness statement including information on my career and role; the Early Intervention in Psychosis ("**EIP**") Service, the role of a community psychiatric nurse ("**CPN**") within the service, risk assessments for patients under the care of the service, the process for raising concerns about patients, and information sharing. I have also been asked to share my reflections and recommendations following VC's attacks, which I have done below.

4. This witness statement was drafted on my behalf by external solicitors and counsel acting for the Trust in respect of the Inquiry, with my oversight and input, following discussions in writing, by email, and by video conference.

CAREER AND ROLE

5. In 2014 I began working as a Healthcare Assistant ("**HCA**") at Newton House care home in Grantham. This was my first role in healthcare. I worked in this role until March 2017. After leaving Newton House, I worked as an HCA at the Manthorpe Centre, Lincolnshire Partnership NHS Foundation Trust, until December 2017.

6. After this I began my nursing training. Between January 2018 and January 2020 I completed an MSc Graduate Entry Nursing (Mental Health) at the University of Nottingham, for which I achieved a distinction.

7. After qualifying, I began working for NHFT as a Band 5 Staff Nurse at Bracken House in January 2020. Bracken House is a rehabilitation unit for men and women between the ages of 18 and 65, and those over 65 who are already accessing adult mental health services. I was in this role until October 2020, when I became a Band 5 CPN at City East Local Mental Health Team ("**LMHT**").

8. On 11 July 2022 I moved into my current role working as a CCO for Nottingham's EIP City South team. VC was already under the care of this team when I joined. By September 2022, when VC was discharged from the EIP City South team, I was still building up my caseload and I had approximately 10 patients. I was not directly involved in VC's care, because Gary Carter was his CCO at the time. Any information I received about VC was therefore mostly through Multi-Disciplinary Team ("MDT") meetings.

9. Since joining the EIP, my caseload has rarely gone above 15 patients. I do not recall when it has done so, or how long for. My caseload has been of similar size to that of my colleagues. When assessing new patients, the EIP City South team will allocate a CCO based on caseload numbers and complexity, so that the workload is evenly spread among the team. Sometimes members of the team may have a higher case load. For example, if a CCO has patients who have

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been hospitalised, they may have the capacity to take on additional patients in the community. Generally, my experience has been that my caseload is manageable.

10. I have been asked to provide copies of any email communications that I have access to or received in respect of my involvement with VC during this period. I have located the following two emails:

    a. An email from Gary Carter on 17 July 2022 in which he explains that he was on annual leave for a week, and needed a few matters to be covered. This included a request to ring or text VC on the morning of 18 July 2022, as his medications were due and he may come into SBC (i.e. the Stonebridge Centre, where EIP City South is based) [NHFT0018210, NHFT0017996]. This was followed up by CCO Abigail Parsonage.
    b. An email from Abigail Parsonage (CPN) on 8 September 2022 concerning cover for Gary Carter. The email includes the following action point for VC: "*VC* **GRO-D** *– gary has put this on rio "I feel in the circumstances I will arrange a visit with a colleague to go out and see Valdo to determine his mental state and general wellbeing." Discuss MDT*" [NHFT0018394]. There is no documentation from this MDT, and I do not recall if this was discussed.

THE EIP SERVICE AND ROLE OF THE CPN

Overview

11. The EIP Service provides support for adults experiencing a first episode of psychosis ("**FEP**"), in line with the National Institute for Health and Care Excellence ("**NICE**") guidelines for psychosis and schizophrenia in adults. It is orientated towards recovery and promotes social inclusion and family

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involvement. The purpose of the EIP team is set out in the EIP Operational Policy [NHFT0004012]. The EIP Service treats FEP patients for a maximum of three years.

12. The EIP team receives referrals from GPs, the Crisis Resolution and Home Treatment team ("**CRHT**"), University Mental Health Services, inpatient settings, and from EIP teams in other localities. Patients are often referred to EIP after they have been experiencing hallucinations, feeling paranoid, or having delusional beliefs.

13. Patients under the care of the EIP team will be offered regular visits with their CCO. In other EIP teams, CCOs are sometimes social workers or occupational therapists. However, in the EIP City South team all CCOs are CPNs. CCO visits will initially take place weekly. As a patient's treatment progresses, meetings may become less frequent if the patient's needs change and they no longer require weekly meetings. Patients also have regular reviews with a psychiatrist as part of their treatment.

14. The types of treatment offered by the EIP are outlined in the EIP Operational Policy [NHFT0004012, pp.18-19]. Treatment can include psychosocial interventions (e.g. Cognitive Behavioural Therapy for psychosis ("**CBTp**") and Behavioural Family Therapy ("**BFT**")) and psychological therapy. The EIP service also prescribes medication. We have a pharmacist on our team who can prescribe medication, or alternatively a patient can be prescribed medication by their consultant.

15. Other aspects of patient care include annual physical health checks, which are offered to all patients on at least an annual basis. Patients have access to Community Support Workers ("**CSWs**"), Peer Support Workers, and employment specialists.

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Monitoring of patients and medication concordance

16. The monitoring of patients under the care of the EIP is carried out during their regular CCO meetings. As I indicated above, these meetings initially take place weekly. CCOs will carry out interventions during appointments including psychoeducation, crisis planning, psychosocial interventions, and medication monitoring in response to the patient's presentation and needs.

17. Patients are also monitored through contact with their CSW, where applicable. If a patient has a CSW, the CSW will feed information back to the CCO about the patient following meetings.

18. In terms of the monitoring and management of medication concordance, this will generally be done by tracking when medication has been dispensed to a patient. The team will track when a patient's medication was last dispensed and how many doses they were given. In this way, we can monitor when a patient is likely to run out of medication, and when they should be coming back to get more medication. If the patient has been prescribed medication directly by the EIP, we are able to monitor this directly. Where a patient's medication is dispensed by their GP, we can contact the GP to ask whether the patient is collecting their medication and if the GP has any concerns. Alternatively, we can access the patient's GP notes on their Notts Care Record, which is accessible on Rio. Generally, GPs will take over responsibility for prescribing a patient's medication where they have become settled on their current dose.

19. If a patient is not taking their medication we will generally book a medication review with one of our medical (i.e. consultant) or non-medical (pharmacist) prescribers to determine the reason why they are not taking their medication. During the review, we discuss with the patient the consequences of not taking medication, and we assess their capacity to decide whether to do so.

20. If the patient who is not taking their medication has capacity, we may consider increasing the frequency of their appointments. This enables the team to monitor the patient to see if there are any early warning signs of relapse. We will also review the patient's Early Warning Signs Plan, which includes information on the signs that may indicate that a particular patient is becoming unwell, and their Crisis Plan. We will ensure that the patient knows what they need to do in the event of a relapse. We include the patient's carer(s) in these plans, where the patient agrees.

21. If the patient does not have capacity, we will again increase our monitoring of the patient to assess them for relapse. We may consider referring the patient to the Crisis team or for a Mental Health Act Assessment ("**MHAA**") if there are signs that the patient is relapsing. If, however, the patient has stopped taking their medication but they are doing quite well, we would likely take less restrictive steps such as talking to their family and carers. The precise steps taken in response to a patient becoming medication non-concordant will therefore vary on a case-by-case basis.

22. I have not had any specific training for non-concordance with medication.

Non-engagement by patients

23. Where a patient does not attend an appointment, it will be their CCO who follows this up. The CCO will attempt to contact the patient, including through text messages, phone calls, letters, emails, and unannounced cold calls to the patient's address. They will also contact third parties to see if there is any relevant information they can provide. These include any allocated social workers, Nottingham Recovery Network (NRN) workers, university mental health services and GPs.

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24. Non-engagement by a patient may indicate that their risk levels have increased. For example, if a patient usually engages very well with the EIP team and suddenly stops engaging or attending appointments, this could be a sign that they have relapsed. However, the extent to which non-engagement is reflective of changes in a patient's risk varies.

25. Where I have a patient who is not engaging or does not attend an appointment, I first try to find other ways to engage the patient. For example, if a patient is not engaging with in-person visits, I explore whether they would prefer telephone or video calls. I try different forms of communication such as text messages, emails, and letters. I may also explore alternative locations for appointments, such as public places or GP surgeries. I also look to consult the patient's friends, their family, their GP, their university (where relevant), and other appropriate persons for information about the patient. I also discuss patients who are not engaging at MDT meetings.

26. Currently, the EIP team also has a weekly risk meeting every Monday. Patients who are not engaging with the team will also be discussed at those meetings, so that the wider team is aware of the non-engagement. This daily meeting was not, however, in place in 2022 when I joined the EIP team. It was put in place after VC had been discharged from the service.

27. I also follow relevant policies for responding to patients who are not engaging. Currently, the EIP Service has a Did Not Attend ("**DNA**") Flowchart [NHFT0018410]. This flowchart sets out, in visual form, the steps that should be taken by members of the EIP team when a patient is not engaging. It explains that where a patient has not attended an existing appointment and is not responding to follow-ups, the CCO should consider the patient's special needs and review their risk assessment, then prioritise a review of the patient's records. The flowchart then sets out different steps that should be followed for low risk (e.g. attempt contact by text, liaise with the patient's GP, consider ad hoc visits) and high risk (e.g. cold calling, consider contacting the police) patients. I do not

remember whether the EIP Service had a DNA Flowchart when I joined the team in 2022, or if it is a more recent change in policy.

28. I can however confirm that Procedure 01.09a, entitled 'Merged Do Not Attends (DNA's)/Cancellations & Management of Patients Who Fail to Engage with Services or Seek to Disengage from Care in an Unplanned Way Procedure' [NHFT0004725], was in place when I joined the EIP team in 2022. This policy details the actions that are to be taken where a patient does not attend an appointment/visit.

29. During my time within the EIP team, I have not been given any specific training on how to manage non-engagement by patients.

The circumstances in which a patient might be considered unsuitable to receive EIP treatment

30. As the EIP Operational Policy sets out [NHFT0004012, p.5], the EIP service is not appropriate for individuals:

    a. Outside the age range of 14-65.
    b. Who have severe learning disabilities with communication difficulties, which render them unable to benefit from the services.
    c. Who are experiencing psychotic symptoms with a confirmed organic cause, for example brain diseases such as Huntington's and Parkinson's disease, HIV or syphilis, dementia, brain tumours or cysts.
    d. Who have an extensive forensic or offending history and are deemed to be at high risk of re-offending, and would be better served by community forensic services.
    e. Whose psychotic symptoms clearly occur only in the context of acute intoxication.

f. Who have already received three years of EIP and have been discharged.

g. Who has already been in contact with Adult Mental Health Services, other than for problems of a 'non-psychotic' nature (e.g. anxiety/depression) and where the current referral for Psychosis is a new emerging phenomenon. Where the individual has been on anti-psychotic medication for another condition for over 12 months the referral will usually not be accepted (save in exceptional circumstances).

h. Who have been assessed as experiencing psychotic symptoms for the first time as a result of pre-existing and longstanding chronic mental health problems such as recurrent depression or Bipolar disorder, personality disorders, or neurodevelopmental disorders.

How the EIP team works with other community and inpatient health services

31. The EIP Service regularly works with other community health services.

32. The main community services that we work with are the Crisis and Home Resolution Team ("**CRHT**") and the Community Forensic Team ("**CFT**"). We will generally work with the CRHT where we think that a patient is at risk of relapse. In terms of the CFT, we will seek advice and/or make referrals to this team where we think that the patient requires specialist forensic support. We also sometimes work with other community services such as the police's Street Triage Team, for example if one of our patients is seen by them.

33. Contact with other community services may also be made at the end of a patient's involvement with the EIP team. At the conclusion of treatment, the patient will be referred to their relevant LMHT if they require further support. Once the patient is allocated a CCO in the LMHT, we will arrange a handover appointment to introduce the patient to the new CCO. We will work with the

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patient to make the handover process as easy as possible. Sometimes, this will mean having several handover appointments.

34. In terms of working with inpatient services, the EIP team regularly receives referrals from inpatient services. Patients already being treated by the EIP team may also be admitted to hospital. Where a new referral or an existing patient is in an inpatient setting, the patient's EIP CCO will attend ward rounds for the patient so that they can receive updates on their condition. The CCO will also prepare social circumstances reports for existing EIP patients for use in Mental Health Tribunals and Hospital Managers' Review Panels.

EIP team meetings

35. The EIP team holds MDT meetings on a weekly basis, every Thursday. They are attended by the whole EIP team including CCOs/CPNs, CSWs, peer support workers, psychiatrists, managers, and pharmacists. Our employment specialists also regularly attend. Since 2022 we have introduced a carer peer support worker, who attends MDTs, and a member of the administrative team who attends to take notes.

36. During MDT meetings the team will discuss new referrals and feedback on assessments of potential new patients that have been carried out by CCOs. We also discuss the patients on our existing caseload, in particular matters that we feel need to be raised with the wider team. This can include raising concerns about a patient's mental health or engagement. It can also include relaying positive feedback to the team after a treatment has been successful.

37. I have been asked a question about a '*weekly review meeting*', and whether this type of meeting is different to an MDT meeting. Since joining the EIP I do not recall there ever being a weekly review meeting additional to the MDT meetings.

38. I have been asked about the EIP team's risk assessment meetings. These have only been introduced after VC's discharge from the EIP Service. These meetings now take place daily. They are facilitated by either a clinical team lead or a team manager, both of whom are nursing staff. Risk assessment meetings are attended by all members of the EIP team. Patients will be discussed at the daily meeting if a member of the team feels that the patient's risks have escalated. These patients will be placed on the 'risk board'. The 'risk board' is an electronic record that can be accessed by the EIP team management. Patients on the risk board, and their care plans, will be discussed daily by the EIP team.

Supervision

39. I have been asked how regularly I was supervised between 2019 and 2023. As indicated, I only joined the EIP team in July 2022. Since then, I have received monthly supervisions. These supervisions have been carried out by either a clinical team lead or a team manager. At any one time, there will be one clinical team lead and one team manager in the EIP team. Between July and September 2022, the clinical team lead was Sharon Heath, and the team manager was Emma Robinson. Sharon Heath was my supervisor during this time period.

40. During my supervision meetings, I discuss the following types of patients with my supervisor:

    a. Any patients where I feel that I require extra support. In such cases, seek advice from my supervisor on possible forms of engagement with the patient, treatment planning, or safeguarding concerns.
    b. Any patients who are accessing our interventions, including CBT and BFT.
    c. Any patients that are due to be discharged soon.

My role in decision-making about patients

41. Since joining the EIP team, I feel that my views and knowledge of EIP patients have been given great weight when decisions have been made about patients. Where I am the patient's relevant CCO, I will have had the most frequent direct contact with the patient out of anyone in the EIP team. I have always felt that my views as a CCO/CPN are respected by responsible clinicians when they are taking decisions about patients. Responsible clinicians often ask for my opinion about changes to patients' care plans and discharge. Decisions about patients will also be informed by the knowledge, experience, and views of other CCOs and members of the team.

42. I have always contributed to decisions about patients' medication and discharge. CCOs regularly discuss medication options and side effects of existing medications with our patients, and we share this information within MDT discussions. I also give opinions to the MDT about the types of medication that I think will benefit my patients.

43. Discharge plans will always be discussed at MDT meetings, either at the patient's request or because the EIP team is considering discharging the patient. I am actively involved in these discussions where I am the patient's CCO, offering my view on the patient's history, symptoms, risks, medication, and support in the community.

RISK ASSESSMENT

Risk Assessment by the EIP Team

44. The EIP team continually assesses the risks posed by patients under their care during the course of their admission and treatment.

45. The main types of risks (and risk management techniques/controls) that we encounter in patients are as follows:

a. Risks to self: self-harm, neglect, suicidal ideation, and drug and/or alcohol misuse. Risk management techniques for these risks include referrals to the CRHT for increased support where a patient is self-harming or suicidal, to consider hospital treatment. Where necessary we can also request safeguarding advice from safeguarding leads through the Single Point of Contact ("**SPOC**") referral form. Where a person requires support with personal care, we can refer them to social care services. Where a person is misusing drugs and/or alcohol, we can refer or encourage the patient to self-refer to NRN (Nottingham Recovery Network).

b. Risks from others: domestic abuse, targeted abuse, and cuckooing (i.e. criminal exploitation by individuals or gangs who use the victim's home to deal drugs, store weapons, or carry out sex work or other illegal activities). Where we have concerns that a patient it as risk from others we can make referrals as appropriate, including DASH (domestic abuse, stalking, and honour based abuse) referrals, MASH (Multi-Agency Safeguarding Hub) referrals, and MARAC (Multi-Agency Risk Assessment Conference referrals). We will also report any abuse to the police and inform the patient's GP. We can provide information to patients about Women's Aid and the Nottingham Women's Centre, and information on how to remain safe if they are victims of domestic abuse.

c. Risks to others: violence and aggression, verbal aggression, kidnapping. We will report violence and aggression carried out by patients to the police. We can provide patients with information on the 'Your Choice Project', which is a voluntary behavioural change programme, run by the charity Equation, for adults who want help to

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stop using abusive behaviour towards a current or ex-partner or someone in their family. The EIP team will always see aggressive patients in pairs, and we will arrange appointments at the team's base or at GP surgeries rather than carry out home visits. We have access to alarms in the team base that we can take to patient appointments to alert colleagues if we need support. We also have personal alarms for community visits.

46. For all types of new risk, we will update a patient's risk assessment and add alerts to the patient's notes on Rio. We will make referrals to CRHT and request an MHAA if the patient is unwell.

47. At the beginning of a patient's care, when the team receives a referral, we will consider the risks disclosed by the referrer to determine how quickly we need to assess the patient and whether it will be safe for the team to see the patient at home.

48. During the initial EIP assessment of the patient, the assessors (usually two CCOs) will ask questions related to risk. We use the CAARMS (Comprehensive Assessment of At-Risk Mental States) template to assess risk. This is a standard pro-forma template which is used to give an Overall Symptom Severity Rating to a patient based on factors such as unusual thoughts and experiences, suspiciousness, and abnormal auditory and visual perceptual abnormalities. The types of questions we will ask a patient include whether they are having any thoughts about self-harm or suicide, and whether they are experiencing command hallucinations (i.e. auditory hallucinations instructing the patient to act in specific ways).

49. In all subsequent EIP appointments with a patient, we will continue to monitor their risks and take appropriate steps in response to any changes. Any new risks or changes to existing risks will be raised by the CCO in supervision meetings, MDT meetings, and now also in risk meetings. Where necessary, we will make referrals to the CRHT or request an MHAA for a patient whose risk levels have increased.

50. In terms of the tools available to me from NHFT to carry out risk assessments, there is a standard risk assessment template (the CAARMS template) available on RIO. This template was in use when I joined the EIP team in 2022. I also have access to the "safetool" for assessing a patient's suicide risk. Safetool is a template that can be downloaded on Rio with a set of standard questions to determine a patient's suicide risk.

The Risk Assessment Process

51. The risk posed by a patient to others is assessed by speaking directly with the patient and asking them questions related to their risks. I will also gather relevant information from the patient's medical records, their carer, and other third parties (such as GPs, university mental health services, and the police).

52. The types of risks that I am looking for when carrying out a risk assessment are risks that the patient will cause harm to themselves or others. We will ask the patient if they have any thoughts about harming others, and if they are hearing command hallucinations telling them to harm others. We consider the possibility that patients will accidentally cause harm. We consider mitigating factors for risks, such as the levels of support that the patient has in the community to reduce risk behaviour.

53. A patient's risk assessment is always updated yearly as part of the patient's Care Programme Approach ("**CPA**") review. I will also update a patient's risk

assessment whenever I have identified a change to their identified risks. This includes where I have identified any new risks, or where any previous risks have been mitigated. I will do this if I have had an appointment with the patient where it has become clear that their risk has changed, or I have received information to that effect from a third party involved in the patient's care.

Training

54. I have reviewed my diary and my training folders in my email account, and I can see that I have carried out the following training on risk assessment since joining the EIP:
    a. On 30 November 2023 I was given suicide prevention training provided by the Nottinghamshire Healthcare Suicide Prevention Team.
    b. On 12 June 2024 I was given training on Safetool.
    c. On 2 September 2024 I was given risk documentation and formulation training. This was delivered by Dr Lomas, who is a Consultant Psychiatrist in the CRHT team.

55. I have also done e-learning on suicide risk assessments. I am required to complete this training every three years. I last completed it on 16 October 2025. I do e-learning on clinical risk and safety every three years, and I last completed this module on 10 November 2025.

56. I am familiar with the Royal College of Psychiatrists' College Report 201 entitled *Rethinking risk to others in mental health services* (2016). I have not received any training on this report.

RAISING CONCERNS

57. I have been asked about what processes existed within the EIP team to raise concerns about the risk of harm posed by mental health patients to members of the public.

58. The way in which I would raise any such concerns would be during the weekly MDT meeting. Any concerns that I had about a patient would then be discussed with my managers (i.e. the team manager and the clinical treatment lead). If the risk in question was due to a patient's mental health deteriorating I would refer the patient to the Crisis team for more intense mental health support. I would consider the possibility of hospital admission if the patient's risks could not be contained within the community.

59. Where a patient poses an active risk to members of the public or a known victim, we inform the police of those risks. For example, are informed if a patient is carrying a weapon. Where a patient has caused (or may cause) harm to another person, we will make safeguarding referrals and referrals for assessments such as MARACs.

60. If I considered that a patient was relapsing, I would take the following steps:

    a. Book them in for an urgent review with a medic or a non-medical prescriber to see if there were potential medication changes that might help prevent the relapse, or a Pro Re Nata (PRN) psychotropic medication that could help treat the patient's immediate symptoms.
    b. Refer the patient to the Crisis team for more regular contact and mental health support and monitoring.
    c. Alternatively, if the patient was unwilling to engage with the Crisis team or EIP, I would consider whether the patient was detainable under the MHA and request an MHAA. I would work alongside any carers or other agencies involved in the patient's care to share

information about the suspected relapse and contain the patient's risk.

61. In terms of non-engagement and medication non-concordance by patients, I have set out the relevant processes and steps that would be taken above.

62. I have been asked in what circumstances, if any, I would request a forensic assessment of a patient. This is not something that I have any personal experience doing. However, I am aware that in principle the EIP Service can consult with the Community Forensics Team ("**CFT**"), which provides recommendations on actions to be taken for patients presenting with a risk of harm towards others. We are able to discuss patients with that team and, where necessary, ask the CFT for their advice about referring the patient to the care of the CFT team.

INFORMATION SHARING

Sharing information with other organisations

63. I have been asked to set out what systems were in place within the EIP team for sharing relevant information.

64. NHFT's information governance team deals with any formal requests for information made about a patient, for example requests made by the police for a patient's records. Once the information governance team processes a request, the proposed response is then sent to the patient's CCO, who checks that there is no information that cannot be shared/needs to be redacted. If the requesting party is a carer, the CCO will ask the patient whether they give consent for the information to be shared, and whether there is any information that they do not want to be shared.

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65. Information is routinely shared with patients' GPs. GPs will be sent copies of clinical letters following outpatient appointments, updates regarding assessments patients, and discharge decisions.

66. I have also shared information about patients with other third parties including the police, local authorities, and independent healthcare organisations. I have done so through Microsoft Teams meetings, emails, letters, and telephone discussions. This is because there is not a centralised or shared database through which I can share information with these organisations. The types of information that I will share with these third parties include patient risk assessments and care plans. Information will always be shared in accordance data protection and information governance guidelines.

67. In terms of how other people share information with me, I have not personally needed to request a great deal of information about patients from third parties during my time with EIP City South. I have had occasions where I have received verbal handovers with external care providers or other EIP teams, where a patient has been recently transferred into our service. In those circumstances the EIP team would also be sent key documents on the patient, such as their care plan.

Sharing information with family members

68. In terms of sharing information with a patient's family, I will always ask my patients what information they are happy for me to share with their family members. The sharing of personal patient information with family members is generally dependent on the patient's consent. Information will not be shared with family members where this could put the patient at risk. However, contact with a patient's family can still be made to receive information, even if the patient does not consent to the EIP team sharing any information.

69. In certain circumstances, however, information can be shared with family members without patient consent. This will be the case where the patient presents a risk to themselves or others that outweighs the need for confidentiality. For example, if we are unable to contact a patient and we are concerned for their wellbeing, we will ask family members whether they have had contact with the patient.

70. Where a patient withdraws consent to sharing information with their family, their capacity will always be considered. If the patient does not have capacity to make a decision about sharing information with their family, we will discuss their risks with family members where necessary.

71. Where information about the patient and their diagnosis is shared with family members this will be in written format, through information leaflets, or verbally. Patients can also bring family members to their CCO appointments.

Barriers to information sharing

72. I have been asked whether there were any barriers to the sharing of information relating to a patient's clinical treatment and risk assessment that limited the effectiveness of multi-agency working. In my experience, one issue is that different agencies tend to use different internal systems for making notes and records. Within the EIP, we do not have access to platforms such as SystmOne. This means that we are not always aware that a patient is open to other agencies unless the agency informs us.

INTERACTION(S) WITH VC

73. As I have set out above, I joined EIP City South on 11 July 2022. Between this time and VC's discharge from the EIP team, I was not his assigned CCO. However, there are circumstances in which a CPN will become involved in a

patient's care despite not being their assigned CCO, for example where the CCO is on leave and requires cover. All CCOs will also attend and participate in wider MDT discussions.

74. In VC's case, I did not ever have any direct contact with him, nor did I ever attempt to contact him. I can see from his records that I participated in at least two MDT meetings at which VC's care was discussed on 31 August 2022 and 22 September 2022. I am not named in the records, but as a CCO on the EIP City South team I would have been present at those meetings. I have checked and there was nothing else in my diary on those dates.

75. I do not have any independent memory of the 31 August or 22 September 2022 MDT meeting. I have some more general memories of aspects of VC's case. However, given the passage of time and the coverage that has been given to VC's attacks since 2022, it is sometimes difficult for me to distinguish between my memories of VC's case from the time, and information that I have subsequently learned about his case.

76. It is likely that I first heard about VC either during an MDT meeting or on 18 July 2022, when Gary Carter (VC's CCO), who was about to go on leave, sent an email to me and other CCOs summarising potential action points for his patients (including VC) [NHFT0018210, NHFT0017996].

77. I believe that between July and September 2022 I gained some knowledge of VC's case. As far as I can recall, I was aware that VC had a diagnosis of paranoid schizophrenia. I was aware that his medication concordance and levels of communication with the team had varied. I also knew that he had attended the Stonebridge Centre to collect his medication in the past, but that he often did not stay to talk to his CCO for long. I was aware that VC had required multiple hospital admissions. I was also aware that he had previously held a student hostage in his halls of residence. I do not remember having any further

information about his risk levels or his risk of violence towards others. I do not remember what (if anything) my understanding was of VC's insight into his condition.

78. I do not recall whether I had any discussions about VC with other nurses or doctors. I do not remember having any conversations with Gary Carter about VC. I was, however, a new member of the EIP team during the final few months of VC's treatment by the service. I was not VC's assigned CCO, nor did I ever meet or interact with him. I think that it is therefore unlikely that I would have had any detailed discussions about VC with other members of the team. It is more likely that I learned about VC by listening to discussions between other members of the team during meetings.

79. I do not remember having read VC's care plans and/or risk assessments before the MDT meetings at which his case was discussed.

80. I can see from the records that on 18 August 2022 the MDT noted that VC had applied for access to his documentation and notes. Gary Carter updated that VC had not contacted him after being sent an invite to do so, and that he had not been supplied with medication now for several weeks. Gary Carter said that he would contact VC's mother for help and assistance [NHFT0000168, p.270]. I remember that in his request, VC provided a different address to the address we had on file.

81. On 22 September 2022, I can see from VC's records that the MDT discussed VC's case again. At this meeting, the MDT decided to discharge him back to his GP for non-engagement. The records state that this was because no contact had been made with VC for a period of time, despite attempts to make contact and having done cold calls [NHFT0000168, p.271].

82. In terms of attendees at this meeting, I know that the only other CCO present was Abigail Parsonage. This is because I have checked and we were the only two CCOs in the EIP City South team who were working that week. All the other CCOs were on annual leave, sick leave, or maternity leave. I do not remember who else attended the meeting.

83. As I have said above, I do not remember this specific meeting or any of the discussions that took place. From what I can recall, my understanding of the reason for VC's discharge was that he was not engaging with the EIP team. As indicated above, VC had been disengaging by giving the team the wrong contact address prior to his discharge. He was not answering his phone or attending appointments. He had not been present when the team had attempted to cold call his known addresses. My recollection is that VC's non-engagement was not considered to be unusual, as he often did not engage in appointments and left shortly after being given his medication. At the time, I believe that I agreed with the plan to discharge VC, as we had no way of contacting him or locating him. We would not therefore have been able to request a MHAA.

84. I do not remember what my role was in the discussions that took place on 22 September. However, I believe that members of the team who knew VC, had met and interacted with him, and who had previously been involved in decisions about his care would have been more active in the decision-making process than I was. I had only been in the EIP City South for a short period of time when VC was discharged, and I never met or interacted with him.

85. I do not remember if contact was made with VC's GP to determine if he had contacted them, or to ask if they had any other information.

86. At the time of VC's discharge, I was not aware of the bench warrant for VC that had been issued by Nottingham Magistrates' Court on 22 September 2022. If the EIP team had been aware of the warrant, we would have made contact with

the police for updates and to share information about VC. The warrant would have been considered in the discharge discussion.

87. I do not remember having any conversations about VC outside of MDT meetings, nor do I remember the dates of any other MDTs at which his case was discussed. I do however think that it is likely that VC's case was discussed at meetings other than the 18 August, 31 August and 22 September meetings. My recollection is that in the weeks leading up to VC's discharge there were discussions about his case, and the possibility of discharge due to non-engagement, at MDT meetings.

88. I have not given any interviews or otherwise made any public comments about VC's actions or the matters under investigation by the Inquiry.

RELATED EXPERIENCE

89. To my knowledge, I have never been involved in the care of any other mental health patient who, following discharge or when in the community, killed or seriously injured a member of the public.

REFLECTIONS

90. I would like to express my sympathy for those affected by VC's actions on 13 June 2023 and offer my condolences to the families of Ian Coates, Barnaby Webber, and Grace O'Malley Kumar.

91. I did not ever meet or interact with VC, but when I learned about his attacks I was surprised. I know that his actions affected the members of the EIP City South team who had worked directly with him.

92. My practice has changed as a consequence of VC's attacks. The EIP City South team has changed the way it works, for example through the introduction of the

daily risk meetings that I have discussed elsewhere in my statement. As I have also explained above a member of the admin team now attends all MDTs to take minutes and to create an action log, and audits of all MDT notes are carried out to ensure that discussions are fully recorded.

93. I am aware that for many people, VC's case has raised concerns about risk management and how mental health services should go about discharging patients.

94. As I have explained above, I was only in the EIP City South team for the last two months of VC's care. I am not therefore familiar with the detail of his pathway through mental health services. Nonetheless, I am aware that VC's care has already been subject to multiple investigations. I know that these investigations have raised the issue of whether a Community Treatment Order ("**CTO**") should have been used, and whether VC should have been given depot medication.

95. I agree that depot medication would have helped to monitor VC's medication concordance, and that a CTO would have allowed recall into hospital if VC was relapsing. However, I do think that it is important to recognise that there are limits to the powers of mental health services when faced with a difficult patient. In VC's case, had a CTO or depot been in place, he may have chosen to disengage from EIP services anyway. During VC's treatment by the EIP he repeatedly gave false information about his location and address, meaning that it would not have been possible to locate him in order to effect his recall or administer depot medication. Mental health services do face real difficulties when presented with patients who are determined not to engage, but who do not meet the threshold for recall or detention. I do however recognise that it is difficult to look back and figure out what impact depot and/or a CTO would have had if either had been used in VC's case. Had VC been on depot medication, it is possible that he would not have disengaged from the EIP service. It is impossible for me to say in hindsight whether that would have been the case.

96. I am aware that NHFT's Level 2 Investigation stated that too much emphasis was placed on complying with VC's priorities for his education in the provision of his care. I have been asked whether I consider that there was a reluctance within the EIP team to use diagnostic labels and/or restrictive practices because of the potential adverse impact on VC's long-term prospects and his ability to finish his degree. I do not recall any discussions in which VC's treatment was guided by a reluctance to take steps that might have a negative impact on his education.

97. At EIP City South we work with students regularly, because our catchment area includes both Nottingham universities. We are experienced in diagnosing students with FEP. We support students throughout their studies, helping them to remain at university (where possible), and we apply least restrictive principle. However, we do use more restrictive practices where we consider that this is required either for the safety of the patient or the safety of others. We work alongside universities to help students to return to their studies after treatment. We liaise with the mental health advisory services to support this.

98. I have been asked whether I was aware of concerns about the disproportionate overuse of MHA restrictive measures with Black African and Black Caribbean patients, publicised in the context of reforms to the MHA. I am aware of these concerns. However, in my experience the EIP City South team has never discussed avoiding restrictive practices based on race.

99. I am aware that each of the existing investigations into VC's care has provided areas of learning both for the EIP team, and for other mental health services. Overall, I think that this was a highly complex situation in which a patient (VC) had repeated contact with mental health services (inpatient and community), police, and higher education bodies. Each of those services had their own processes, data systems, and procedures to follow. Those processes did not always align, and communication between services was not always as effective as it could have been. VC's attacks have therefore highlighted the gaps that exist within and between the different services that were involved in his care.

100. In terms of other reflections that I have following VC's attacks, I am concerned about the impact of the public and media response to the attacks. I am particularly concerned about the portrayal of VC as a 'monster', as he has been labelled in the press. In my view, this portrayal has reinforced harmful negative stereotypes about people with severe mental illness, namely that they are likely to be violent.

101. In my clinical practice since VC's attacks, I have assessed new patients to the EIP service who have said that they are worried that they will 'become like VC'. Patients have been scared to seek support or share their diagnosis with others due to concerns about how they may be perceived or treated, fearing that they will be locked away. There remains a significant stigma around mental illness. In my view the portrayal of VC, who at the time of the attacks was a severely unwell man, as a 'monster' reinforces this stigma. This risks others not engaging with mental health services where they should do, increasing shame and worsening the outcomes of patients who are already vulnerable. It is my understanding that people with schizophrenia are more likely to be victims of crime rather than perpetrators, and VC's case should not be used to define an entire section of the population.

102. The tragic events of 13 June 2023 provide the opportunity for all public services to improve their outcomes. I believe that these improvements need to occur alongside tackling stigma associated with mental illness, and improving public knowledge on mental health, in order to support people to feel safe and to seek help where they need to do so.

RECOMMENDATIONS

103. The practice of the EIP City South team has already changed in light of VC's attacks. The introduction of our daily risk meetings and improvements to

MDT meetings have made the team more efficient at documenting and discussing patient risk.

104. As I have indicated above, in my view the response to VC's attacks has demonstrated a general lack of knowledge and understanding of psychosis within the general public, and continued stigma surrounding mental illness. I think that better education on serious mental illness may help reduce this stigma and encourage more people to seek help.

105. In terms of improvements that could be made locally and nationally to multi-agency working to increase effectiveness and prevent similar outcomes in the future, I think that better communication between services would enable those of us working within them to have a better understanding of a patient's life and circumstances. This will ensure that better and more informed decisions are made. For example, the EIP City South team was not aware of VC's bench warrant, and nor was the Magistrates' Court aware that we were considering discharging VC at the time the warrant was issued. Additionally, mental health services use different record-keeping systems in different localities. If VC had come into contact with services in a different county, they would not have had access to his notes on Rio unless VC shared that information voluntarily.

Statement of Truth

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: GRO-B

Dated: 27/1/2026

Index to First Witness Statement of Frances Bayer

No	Inquiry URN	Document Description
1	NHFT0018210	Email from Gary Carter to the EIP City South team on 17 July 2022 at 10:27
2	NHFT00179[9]6	Attachment to email from Gary Carter to the EIP City South team on 17 July 2022 at 10:27
3	NHFT0018394	Email from Abigail Parsonage to the EIP City South team on 8 September 2022 at 12:50
4	NHFT0004012	EIP Operational Policy
5	NHFT0018410	DNA Flowchart
6	NHFT0004725	Procedure 01.09a: Merged Do Not Attends (DNA's)/Cancellations & Management of Patients Who Fail to Engage with Services or Seek to Disengage from Care in an Unplanned Way Procedure
7	NHFT0000168	Medical Records of VC from 24/05/2020 to 14/06/2023, Various NHFT Staff/Teams, re: Patient Record Summary